VIRGINIA
PHYSICAL ASSESSMENT

Last Name _____ First _____ MI _____

SSN: _____ Medicaid #: _____

1. **Vital signs**

a. Height in inches: _____ b. Weight _____ c. Frame: ☐ Small ☐ Medium ☐ Large

d. BP _____ Pulse _____ Respiratory rate _____

e. Stability of the individual's condition: ☐ Improving ☐ Stable ☐ Deteriorating ☐ Unstable

2. **Medications:**	**Dosage:**	**Purpose:**

3. **Neurological Assessment:** *Coding* *Y=Yes* *N=No* *U=Uncooperative*

a. Motor functioning

Y N U

☐☐☐ Can reach for and lift an object
☐☐☐ Can brush/comb own hair
☐☐☐ Can stand up straight
☐☐☐ Abnormal involuntary movements

b. Fine motor skills

Y N U

☐☐☐ Can pick up pencil/pen
☐☐☐ Can button shirt
☐☐☐ Can tie shoe string
☐☐☐ Able to appreciate touch

c. Visual sensory functioning

Y N U

☐☐☐ Pupils equal
☐☐☐ Pupils follow lateral movement
☐☐☐ Pupils react to light
☐☐☐ Nystagmus present

d. Oral sensory functioning

Y N U

☐☐☐ Tongue deviates to L/R
☐☐☐ Stridor/hoarseness/dysarthria present
☐☐☐ Uvula is central
☐☐☐ Abnormal involuntary movement
☐☐☐ Pharyngeal muscles contract

e. Cranial nerves

Y N U

☐☐☐ Masseters tighten with jaw clenched
☐☐☐ Able to feel touch on face
☐☐☐ Able to smile and say "E"
☐☐☐ Mouth deviates to L/R when smiling

f. Eye/hand coordinator

Y N U

☐☐☐ Can touch nose with finger
☐☐☐ Can touch assessors extended index finger
☐☐☐ Can catch an object
☐☐☐ Can copy a circle/s

VIRGINIA PHYSICAL ASSESSMENT (continued)

g. Spine and Peripheral nerves

Y	N	U	
☐	☐	☐	Neck is supple
☐	☐	☐	Spinal curvatures are normal
☐	☐	☐	Able to shrug shoulder against resistance
☐	☐	☐	Able to turn neck against resistance

h. Gait

Y	N	U	
☐	☐	☐	Normal
☐	☐	☐	Wide-stepping
☐	☐	☐	Shuffling
☐	☐	☐	Paretic

I. Normal reflexes left side

Y	N	U	
☐	☐	☐	Tricep joint
☐	☐	☐	Bicep joint
☐	☐	☐	Wrist joint
☐	☐	☐	Knee Joint
☐	☐	☐	Achilles joint
☐	☐	☐	Plantars

j. Normal reflexes right side

Y	N	U	
☐	☐	☐	Tricep joint
☐	☐	☐	Bicep joint
☐	☐	☐	Wrist joint
☐	☐	☐	Knee joint
☐	☐	☐	Achilles joint
☐	☐	☐	Plantars

4. **Review of Systems** *Mark the "Yes" or "No" box as indicated by the individual, staff, or chart review, if the individual is experiencing the following problems. Please indicate source of information.*

a. **Neurological problems?** ☐ No ☐ Yes

☐ Headaches ☐ Migraines ☐ Seizures/Spells ☐ Tremors
☐ Dizziness ☐ Blackouts/Fainting ☐ Unsteady balance/gait ☐ Numbness

Comments: _____

b. **Vision problems?** ☐ No ☐ Yes

☐ Blurred vision ☐ Double vision ☐ Lights/Spots ☐ Field cut
☐ Vision loss ☐ Unequal pupils ☐ Reading small print ☐ Corrected with glasses

Comments: _____

c. **Hearing problems?** ☐ No ☐ Yes

☐ Hearing others ☐ Hearing in groups ☐ Hearing whispers ☐ Pain in ears ☐ Corrected with aid/device

Comments: _____

d. **Nose problems?** ☐ No ☐ Yes

☐ Nasal congestion ☐ Frequent runny nose ☐ Decreased ability to smell ☐ Nose bleeds

Comments: _____

e. **Mouth problems?** ☐ No ☐ Yes

☐ Gums bleed/sore ☐ Loose teeth ☐ Tooth decay ☐ Teeth missing
☐ Dry mouth ☐ Corrected with aid/device

Comments: _____

f. **Throat/Neck problems?** ☐ No ☐ Yes

☐ Frequent sore throats ☐ Choking episodes ☐ Difficulty swallowing ☐ Lump in throat

Comments: _____

Name: _____

VIRGINIA PHYSICAL ASSESSMENT (continued)

g. **Cardiovascular problems?** ☐ No ☐ Yes

☐ Pain on exertion ☐ Non-exertional pain ☐ Irregular beat ☐ ASHD
☐ Hypertension ☐ Hypotension ☐ Previous CVA ☐ Bypass

Comments: _____

h. **Circulatory problems?** ☐ No ☐ Yes

☐ Night calf pain ☐ Pain when walking ☐ Edema of legs/feet ☐ Varicose veins ☐ Ulcers on lower leg

Comments: _____

i. **Pulmonary problems?** ☐ No ☐ Yes

☐ Productive cough ☐ Nonproductive cough ☐ SOB lying flat ☐ SOB at rest
☐ SOB on exertion ☐ Paroxysmal nocturnal dyspnea

Comments: _____

j. **Upper GI problems?** ☐ No ☐ Yes

☐ Food intolerance ☐ Loss of appetite ☐ Indigestion ☐ Belching/gas
☐ Nausea/Vomiting ☐ Abdominal pain after meal ☐ Intermittent pain

Comments: _____

k. **Lower GI problems?** ☐ No ☐ Yes

☐ Diarrhea ☐ Constipation ☐ Fecal incontinence ☐ Impactions
☐ Hemorrhoids ☐ Bloody/Tarry stools

Comments: _____

l. **Bowel management?** ☐ No ☐ Yes

☐ Prune/other juice ☐ Bran ☐ Daily laxative ☐ Laxative PRN ☐ Enemas ☐ Suppositories

Comments: _____

m. **Urological problems?** ☐ No ☐ Yes

☐ Burning/Pain ☐ Dribbling/Leaking ☐ Frequency/Urgency ☐ Nocturia
☐ Incontinence ☐ Perineal irritation ☐ Discharge

Comments: _____

n. **Musculoskeletal problems?** ☐ No ☐ Yes

☐ Paralysis in:	☐ Right arm	☐ Right leg	☐ Left arm	☐ Left leg
☐ Contractures in:	☐ Right arm	☐ Right leg	☐ Left arm	☐ Left leg
☐ Weakness in:	☐ Right arm	☐ Right leg	☐ Left arm	☐ Left leg
☐ Pain in:	☐ Hips	☐ Knees	☐ Back	☐ Hands

☐ Other: _____

Comments: _____

VIRGINIA PHYSICAL ASSESSMENT (Continued)

o. **Skin problems?** ☐ No ☐ Yes

☐ Rash ☐ Dry skin ☐ Fragile skin ☐ Itching
☐ Change in freckle/mole ☐ Pressure sore ☐ Stasis ulcer

Comments: _____

p. **Endocrine Problems?** ☐ No ☐ Yes

☐ Excessive thirst ☐ Excessive hunger ☐ Cold sensitivity ☐ Diabetic

Comments: _____

5. **Special Treatments**

a. *Please indicate which of the following special medical treatments the individual currently receives (mark all that apply):*

☐ Catheterization care
☐ Colostomy care (Ileostomy)
☐ Decubitus care
☐ Fracture care
☐ Gastrostomy
☐ Inhalation therapy
☐ Intake and output
☐ Medication monitoring
☐ Oral suction
☐ Prosthesis care TPR/BP
☐ Special skin care
☐ Sterile dressings
☐ Therapeutic diets
☐ Tube feedings
☐ Other (specify): _____
☐ Other (specify): _____

b. *Please indicate if the individual currently receives any of the following restorative nursing services:*

☐ None ☐ Walking ☐ Transferring ☐ Dressing ☐ Bathing
☐ Eating ☐ Bed mobility ☐ Grooming ☐ Bladder/Bowel Other *(specify):* _____

Comments:

_____

_____

_____

_____

_____

PHYSICIAN SIGN-OFF

_____ _____ _____
Print name: Signature: Date:

_____ _____ _____
Address: City: Zip: Phone: